PRINTED: 07/11/2011 FORM APPROVED

CENTERS FO	OR MEDICARE & MEDI	CAID SERVICES			(OMB NO. 0938-0391
STATEME	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER:	, print puric	00		
		155616	A. BUILDING B. WING		06/17	7/2011
		1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	ER	I	ELM ST		
LANDM	ARK NURSING AN	D REHABILITATION		LBANY, IN47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDENCE N. AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	ENCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ORRECTION I	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NAIE	DATE
F0000						
	l					
		for a Recertification and	F0000	This plan of correction is		
	State Licensure Survey. Survey dates: June 13, 14, 15, 16, and 17, 2011			serve as Landmark Nurs Rehabilitation Center's c	-	
				allegation of compliance		
				Submission of this plan		
				correction does not cons		
				an admission by Landma	ark	
	Facility number	r: 001145		Nursing & Rehabilitation		
	Provider number			Center or its managemer		
	Aim number :			company that the allegat		
		200120200		contained in the survey r	-	
	Survey team:			is a true and accurate po of the provision of nursir	-	
	Gloria J. Reiser	+ MSW/TC		and other services in this	_	
				facility. Nor does this		
	Dorothy Navett			submission constitute ar	า	
	Avona Connell			agreement or admission	of the	
	Donna Groan R	SN .		survey allegations.		
	,					
	Census bed typ	e:				
	SNF/NF: 66					
	Residential: 15					
	Total: 81					
	1					
	Census payor ty	ype:				
	Medicare: 10					
	Medicaid: 48					
	Other: 23					
	Total: 81					
	G					
	Sample: 15		ı			1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Supplemental sample: 8 Residential sample: 7

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UQNE11

Facility ID:

If continuation sheet

TITLE

001145

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616 NAME OF PROVIDER OR SUPPLIER LANDMARK NURSING AND REHABILITATION				LDING STREET A 201 E E	ADDRESS, CITY, STATE, ZIP CODE ELM ST LBANY, IN47150	(X3) DATE COMPI 06/17/2	LETED
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	findings cited in 16.2.	ies also reflect state a accordance with 410 IAC completed 6/21/11 or RN					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UQNE11 Facility ID:

lity ID: 001145

If continuation sheet

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	NINC	00	COMPL	ETED
		155616	B. WING			06/17/2	011
			p. white		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			201 E E			
LANDMA	RK NURSING AND	REHABILITATION			LBANY, IN47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0157	•	nediately inform the					
SS=D		vith the resident's physician;					
		y the resident's legal					
	-	an interested family member					
		accident involving the					
		ults in injury and has the ing physician intervention; a					
		in the resident's physical,					
	•	social status (i.e., a					
	deterioration in he						
		is in either life threatening					
		cal complications); a need to					
	alter treatment sig	nificantly (i.e., a need to					
	discontinue an exi	sting form of treatment due					
		quences, or to commence a					
		nent); or a decision to					
		ge the resident from the					
	facility as specified	d in §483.12(a).					
	The facility must a	Iso promptly notify the					
	•	own, the resident's legal					
		nterested family member					
	-	lange in room or roommate					
		ecified in §483.15(e)(2); or					
		ent rights under Federal or					
	•	ations as specified in					
	paragraph (b)(1)	of this section.					
		ecord and periodically					
	•	s and phone number of the					
		oresentative or interested					
	family member.	the state of the state of	F01		I. An Ortho consult for R56 w	,oo	07/1//2011
		review and interview, the	F01	3/	discontinued per his primary	as	07/16/2011
		ensure the physician was	1		physician. On June , 2011 R	251's	
	notified of a refe	rral not being done for 1			primary physician and ENT v		
	of 1 resident with	n a referral to an			notified of referral to oral		
	orthopedic [ortho	o] doctor in a sample of	1		surgeon. II. All residents witl	n	
		(6); and failed to notify			specialty referrals are at risk	to be	
	· ·	-	1		affected. All resident records		
		ysician and ENT [ear,			were reviewed and no		
	nose and throat	specialist when the			outstanding referrals were no	oted.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155616	B. WIN			06/17/2	011
		II	P		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t .		201 E E	ELM ST		
	ARK NURSING AND	REHABILITATION			LBANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	consultant dentis				III. The policy for Physician Notification was reviewed a	nd	
	recommendation for evaluation of an irregular area noted to the resident's tongue. This deficient practice affected 1 of 1 resident reviewed for dental referral				found to be appropriate by		
					Committee. All nurses were		
					reeducated on Physician		
					Notification Policy. IV. Direc		
	in a sample of 15	5 residents. (Resident			Nursing or designee will rev telephone orders daily to ide		
	#51)				outstanding specialty referra	, i	
					Director of Nursing or desig		
	Findings include	:			will review documentation for		
	i manigo merade.				those residents with special	ty	
	1. The clinical re	ecord for Resident #56			referrals to assure proper physician notification. Direc	tor of	
	was reviewed on	6/14/11 at 1:25 p.m.			Nursing or designee will rep		
		agnoses included, but			audit findings to QA monthly		
	were not limited	-			three months and quarterly,		
		fracture distal second,			thereafter. V. Date of Comp	letion:	
	1 ^	I fifth metatarsals of			July 16, 2011		
		The resident had an X-ray					
	1	completed on 5/24/11.					
	1	•					
	1 -	included, but was not					
		ures of the distal second,					
		I fifth metatarsals." On					
	_	to the physician on					
		o.m., was a note faxed					
	1	ysician "refer to ortho"					
		e physician on 5/24/11 at					
	1923 (7:23) p.m.						
		n the Director of Nursing					
	on 6/14/11 at 2:	10 p.m., she indicated she					
	knew the consul	t had been completed, but					
	documentation v	vas lacking. No					
	documentation	-					
	was found of the	consult being obtained.					
		as notified on 6/16/11 at					

001145

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						1	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL		
		155616	B. WIN			06/17/2	011	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
LANDAAA		DELLABULITATION		201 E E				
LANDMA	ARK NURSING AND	REHABILITATION		NEW A	LBANY, IN47150			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
IAG		LSC IDENTIFYING INFORMATION)		TAG	DEFECT.)		DATE	
	11:05 a.m., at which time he canceled the ortho referral.							
	ortho referral.							
	Dogumentation u	was looking in the alinical						
		was lacking in the clinical						
	record of the physician being notified the referral had not been completed.							
	i referrar nau not c	ocen completed.						
	2 Review of the	clinical record for						
		6/14/2011 at 1:50 p.m.,						
		ident had diagnoses						
		but were not limited to,						
		t diabetes mellitus,						
	1	isease, congestive heart						
	1 -	oesophageal reflux						
	disease.	oesophagear remax						
	arsease.							
	On 4/11/2011, th	e consultant dentist						
	· ·	the following notations						
		ution: "Mixed red/white						
	area 4 x [by] 5 m	m [millimeter] irregular						
	""	ue. Referral to oral						
	-	teral tongue area -						
	Biopsy? #30 -31	· ·						
	Review of the nu	irsing and social worker						
		11/2011 and 6/15/2011						
	failed to locate d	ocumentation of the						
	resident's primary	y physician and ENT						
		been notified of the						
	dentist's findings							
	During an intervi	iew with RN #1 and						
	LPN #1 on 6/16/2	2011 at 12:20 p.m., they						
	indicated they we	ere unaware if the						

NAME OF PROVIDER OR SUPPLIER LANDMARK NURSING AND REHABILITATION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG Documentation in the physician's progress notes indicated the primary physician had made a visit to see the resident for his routine check up on the evening of 4/11/2011. There was no reference to the lesion found in the resident's mouth earlier that day by the dentist. The facility also placed calls to, or the resident saw. the ENT specialist on the following dates with no documentation of the specialist being made aware of the lesion: 4/12/2011, 5/2/2011, 5/9/2011, and May 13, 2011.			X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER LANDMARK NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) primary physician and ENT specialist had been notified. Documentation in the physician's progress notes indicated the primary physician had made a visit to see the resident for his routine check up on the evening of 4/11/2011. There was no reference to the lesion found in the resident's mouth earlier that day by the dentist. The facility also placed calls to, or the resident saw, the ENT specialist on the following dates with no documentation of the specialist being made aware of the lesion: 4/12/2011, 5/2/2011, 5/9/2011, and	ANDILAN	or correction		1	00	
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CANDMARK NURSING AND REHABILITATION NEW ALBANY, IN47150	NAME OF P	'ROVIDER OR SUPPLIER		- 1		
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) primary physician and ENT specialist had been notified. Documentation in the physician's progress notes indicated the primary physician had made a visit to see the resident for his routine check up on the evening of 4/11/2011. There was no reference to the lesion found in the resident's mouth earlier that day by the dentist. The facility also placed calls to, or the resident saw. the ENT specialist on the following dates with no documentation of the specialist being made aware of the lesion: 4/12/2011, 5/2/2011, 5/9/2011, and						
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earlier that day by the dentist. The facility also placed calls to, or the resident saw. the ENT specialist on the following dates with no documentation of the specialist being made aware of the lesion: 4/12/2011, 5/2/2011, and		4/11/2011. There	was no reference to the			
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following dates with no documentation of the specialist being made aware of the lesion: 4/12/2011, 5/2/2011, and		The facility also	placed calls to, or the			
the specialist being made aware of the lesion: 4/12/2011, 5/2/2011, 5/9/2011, and		resident saw. the	ENT specialist on the			
lesion: 4/12/2011, 5/2/2011, 5/9/2011, and		following dates v	vith no documentation of			
		the specialist being	ng made aware of the			
May 13, 2011.		lesion: 4/12/2011	, 5/2/2011, 5/9/2011, and			
		May 13, 2011.				
3.1-5(a)(3)		3.1-5(a)(3)				
F0253 The facility must provide housekeeping and	E0253	The facility must n	rovide housekeeping and			
SS=E maintenance services necessary to maintain						
a sanitary, orderly, and comfortable interior.		· · ·				.
Based on observation, record review and interview, the facility failed to ensure 1. Ceiling fan blades of fans by nurse's station 1,2,3, and by				F0253		
rooms 23 25 29 44 and 51		· ·	•			
furniture, over the bed lights, and ceiling were cleaned. Room 42The		l '	C , C		were cleaned. Room 42Th	ne
fans were clean and in good repair during frame of 1 bed, 2 closet tops and		fans were clean a	and in good repair during		frame of 1 bed, 2 closet top:	s and

NAME OF PROVIDER OR SUPPLIER 155616 S WING	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
International Name of Provider or Supplier Street Address, City, State, 2ip Code	AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPI	LETED
201 E ELM ST NEWALBANY, INA7150 NEWALBANY, INA7150 NEWALBANY, INA7150 SUMMARY STATEMENT OF DEFICIENCES GEACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Troms on Hall #1, 3 of 7 rooms on Hall #2, 4 of 13 rooms on Hall #4. ### and 6 of 30 rooms on Hall #4. Sof 7 rooms on Hall #4. ### and 6 of 30 rooms on Hall #4. Sof 8 rooms on Hall #4. ### and 6 of 30 rooms on Hall #4. Sof 9 rooms on Hall #4. ### and 6 of 30 rooms on Hall #4. Sof 9 rooms on Hall #4. ### and 6 of 30 rooms on Hall #4. Sof 9 rooms on Hall #4. ### and 6 of 30 rooms on Hall #4. Sof 9 rooms on Hall #4. ### and 6 of 30 rooms on Hall #4. Sof 9 rooms on Hall #4. ### and 6 of 30 rooms on Hall #4.			155616				06/17/2	011
ANDMARK NURSING AND REHABILITATION CAJ ID SUMMARY STATEMENT OF DEFICIENCIES PREETX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX TAG PRECIDENCY MUST BE PERCEDED BY FULL TAG PRECIDENCY MUST BE PRECEDED BY FULL BE PRECEDED BY FULL BE PRECEDED BY FULL BE P	NAME OF F	DOLUDED OD GLIDDLIEF	`		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG ROW of A call gift were dusted. The cubicle curtain was cleaned. Room 49-The frame of 1 bed, 2 closest tops were dusted. The cubic curtain was cleaned. The cubic curtain was cleaned. Room 49-The frame of 2 beds, 2 over bed lights and 2 closest tops were dusted. The cubic curtain was cleaned. Room 53The frames of 2 beds, 2 over bed lights and 2 closest tops were dusted. Room 31The frame of 1 bed, and 2 closet tops were dusted. Room 31The frame of 1 bed, 1 over bed light and 1 closet top were dusted. Room 31The frame of 1 bed, and 2 closet tops were dusted. The wall below the bathroom hand sink was cleaned. Room 31The frame of 1 bed, and 2 closet tops were dusted. The wall below the bathroom hand sink was cleaned. Room 31The frame of 1 bed, and 2 closet tops were dusted. A filter was placed in the oxygen concentrator. The celling tile over the shower was replaced. The wood frame of a chair outside of the beauty shop was dusted. Room 124The frames of 2 beds were dusted. Room 124The frame of 1 bed was dusted. Room 124The frame of 1 bed was dusted. Room 144The frame of 1 bed was dusted. Room 154The frame of 2 beds were dusted. Room 154The frame	NAME OF F	ROVIDER OR SUPPLIER			201 E E	ELM ST		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) environmental observations on 2 of 5 survey days. This deficient practice affected 2 of 9 rooms on Hall #1, 3 of 7 rooms on Hall #2, 4 of 13 rooms on Hall #4. #3 and 6 of 30 rooms on Hall #4. Findings include: 1. On 06/13/11 at 1:15 p.m., the blades of a ceiling fan above the nurses station for Hall 1, 2, and 3 were soiled with black dust. 2. At 1:30 p.m., the blades of the ceiling fans in the hallway by rooms 23, 25, 29, 44 and 51 were soiled with black dust. On 06/16/11 between the hours of 9:28 a.m. and 10:32 a.m., the following was noted: 3. Room 42The frame of 1 bed, 2 closet tops and 1 over bed light were soiled with the fingers. The cubicle curtain was cleaned. Room 49-The top of the mirror in the bathroom was cleaned. Room 53-The frames of 2 beds, 2 over bed lights and 2 closet tops were dusted. The cubicle curtain was cleaned. Room 53-The frame of 1 bed, 1 over bed light and 1 closet top were dusted. The chair was removed. Room 31-The frame of 1 bed, and 2 closet tops were dusted. Room 29-The frame of 1 bed, and 2 closet tops were dusted. Room 29-The frame of 1 bed, and 2 closet tops were dusted. Room 11-The frame of 1 bed, and 2 closet tops were dusted. Room 29-The frame of 1 bed, and 2 closet tops were dusted. Room 29-The frame of 1 bed, and 2 closet tops were dusted. Room 11-The frame of 1 bed, and 2 closet tops were dusted. Room 12-The frame of 1 bed, and 2 closet tops were dusted. Room 12-The frame of 1 bed, and 2 closet tops were dusted. Room 12-The frame of 1 bed, and 2 closet tops were dusted. Room 12-The frame of 1 bed, and 2 closet tops were dusted. The cubicle of the beauty shop was dusted. Room 124-The frames of 2 beds were dusted. Room 129-The frame of 1 bed was dusted. Room 129-The frame of 1 bed was dusted. Room						LBANY, IN47150		
environmental observations on 2 of 5 survey days. This deficient practice affected 2 of 9 rooms on Hall #1, 3 of 7 rooms on Hall #2, 4 of 13 rooms on Hall #4. #3 and 6 of 30 rooms on Hall #4. Findings include: 1. On 06/13/11 at 1:15 p.m., the blades of a ceiling fan above the nurses station for Hall 1, 2, and 3 were soiled with black dust. 2. At 1:30 p.m., the blades of the ceiling fans in the hallway by rooms 23, 25, 29, 44 and 51 were soiled with black dust. On 06/16/11 between the hours of 9:28 a.m. and 10:32 a.m., the following was noted: 3. Room 42The frame of 1 bed, 2 closet tops and 1 over bed light were soiled with the fingers. The cubicle over the shower was replaced. The wood frame of a chair outside of the beauty shop was dusted. Room 124The frame of 1 bed, 2 closet tops and 1 over bed light were soiled with the fingers. The cubicle up when wiped with the fingers. The cubicle						PROVIDER'S PLAN OF CORRECTION		
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#3 and 6 of 30 rooms on Hall #4. #3 and 6 of 30 rooms on Hall #4. #3 and 6 of 30 rooms on Hall #4. #4 and 51 were soiled with black dust. #5 a.m. and 10:32 a.m., the following was noted: #6 a. Room 42The frame of 1 bed, 2 closet tops ware dusted. The cubicle curtain was cleaned. Room 53The frames of 2 beds, 2 over bed lights and 2 closet tops were dusted. Room 40The top of 1 closet was dusted. The chair was removed. Room 31The frame of 1 bed, 1 over bed light and 1 closet top were dusted. Room 29The frame of 1 bed and 1 over bed light were dusted. The wall below the bathroom hand sink was cleaned. Room 24The cover for the electric plug was repaired and cleaned. Room 11The frame of 1 bed, and 2 closet tops were dusted. The wall below the bathroom hand sink was cleaned. Room 24The cover for the electric plug was repaired and cleaned. Room 11The frame of 1 bed, and 2 closet tops were dusted. The wall below the bathroom hand sink was cleaned. Room 24The cover for the electric plug was repaired and cleaned. Room 11The frame of 1 bed, and 2 closet tops were dusted. The cover for the electric plug was repaired and cleaned. Room 12The frame of 1 bed, and 2 closet tops were dusted. Room 12The frame of 1 bed and 1 over bed light were was repaired and cleaned. Room 12The frame of 1 bed, and 2 closet tops were dusted. Room 24The cover for the electric plug was repaired and cleaned. The wood frame of a chair outside of the beauty shop was dusted. Room 124The frames of 2 beds were dusted. Room 129The frame of 1 bed was dusted. Room 129The fra		affected 2 of 9 rd	ooms on Hall #1, 3 of 7					
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when when with the inigers. The cubicity is a second of the cubicity of the cu			3					
I I 130. The frames of 2 hode were		_				130The frames of 2 beds w		
curtain was soiled with small brown dusted. Room 132The frames			ed with small brown			dusted. Room 132The fram	nes	
stains. of 2 beds and 2 over bed lights		stains.				_		
were dusted. Room 111The								
4. Room 49The frame of 1 bed, 1 wood frame of 1 bed and 1 closet top		4. Room 49Tl	he frame of 1 bed, 1 wood				-	
chair frame, 2 over bed lights and 2 closet were dusted. Room 107The frame of 1 bed, 1 over bed light		chair frame, 2 ov	ver bed lights and 2 closet					
tops were soiled with heavy dust. The and wood frame of 1 chair were		tops were soiled	with heavy dust. The				-	
cubicle curtain was soiled with a white dusted. The bumper under the		•	•					
and black substance and the Television hand rail outside of room 104 was								

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPI		
THIND TEXT	or conduction	155616	1	LDING		06/17/2	
		1 .555.5	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	₹		201 E E			
LANDM	ARK NURSING AND	REHABILITATION		1	LBANY, IN47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		with black dust. The top			dusted and corner piece wa replaced. The bumper unde		
	1	the bathroom was soiled			hand rail by room 132 was	i uic	
	with a white pov	vdery substance.			dusted. Corner pieces were		
					replaced on the bumper und		
	5. Room 53Th	ne frames of 2 beds, 2			hand rail between rooms 13		
	over bed lights a	and 2 closet tops were			132. II. Environmental round were completed throughout		
	soiled with heav	y dust.			entire facility to identify any		
					soiled, damaged, missing of		
	6. Room 40Th	ne top of 1 closet was			discolored items and/or area	as. III.	
	soiled with heavy dust. The wood frame of 1 chair was marred and the seat was stained.				Routine cleaning duties,	. ما	
					schedule, sign off sheets ar maintenance requisitions we		
					drafted and approved by QA		
					Committee. All housekeepir		
	7. Room 31The frame of 1 bed, 1 over				maintenance staff were		
	bed light and 1 closet top were soiled with				re-educated on proper clear		
	heavy dust.	•			and repairs, routine cleaning duties, schedule and sign o		
					sheets. IV. The Administrate		
	8. Room 29Th	ne frame of 1 bed and 1			designee will review sign of		
	over bed light w	ere soiled with heavy			sheets and maintenance re		
	1	s were noted on the wall			requisitions and conduct rar audits of facility areas daily		
	below the bathro	oom hand sink.			walking rounds to identify a		
					environmental needs. The r	esults	
	9. Room 24Th	ne cover for the electric			of these audits will be review		
		and only covered half of			by QA weekly for four week monthly for 2 months and th		
	the outlet.	.			quarterly thereafter. V. Date		
					Completion: July 16, 2011		
	10. Room 11	The frame of 1 bed, and 2					
		soiled with heavy dust.					
	1	centrator lacked a filter					
	1	ile over the shower had					
	dried brown stai						
	ariod orowin star						
	11 The wood fr	rame of a chair outside of					
		was soiled with heavy					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	CO	OMPLETED 17/2011	
	PROVIDER OR SUPPLIER			STREET A	ddress, city, state, zip co LM ST _BANY, IN47150	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	dust. 12. Room 124 were soiled with	The frames of 2 beds heavy dust.					
	13. Room 129The frame of 1 bed was soiled with heavy dust.						
	14. Room 130The frames of 2 beds were soiled with heavy dust.						
	15. Room 132The frames of 2 beds and 2 over bed lights were soiled with heavy dust.						
		The frame of 1 bed and 1 oiled with heavy dust.					
	17. Room 107The frame of 1 bed, 1 over bed light and wood frame of 1 chair were soiled with heavy dust						
	outside of room that rolled up wh	under the hand rail 104 was soiled with dust en swiped with the r piece was missing.					
	_	under the hand rail by iled with heavy dust.					
	_	es were missing on the e hand rail between 32.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155616			(X2) MULT A. BUILDII B. WING		NSTRUCTION 00	(X3) DATE S COMPL 06/17/20	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN47150					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE	
	Supervisor at 10: the bed frames at on the residents s provided copies	with the Housekeeping 15 a.m., she indicated re washed 1 time a week shower days. She of work sheets for the rated the resident shower						
F0282 SS=D	facility must be proin accordance with plan of care. A. Based on recordance the facility failed ortho (orthopedia resident reviewed a sample of 15. B. Based on recordance the facility failed and procedure reof constipation for	ded or arranged by the ovided by qualified persons in each resident's written ord review and interview, at to refer a resident for an et consult for 1 of 1 d with an ortho referral in (Resident #56) ord review and interview, at to follow their policy lated to the management or 1 of 2 residents stipation in a sample of	F028	2	I. Ortho consult for R56 was discontinued per his primary physician. R8's BM pattern is being monitored and she has at least one BM every 3 days All resident's records were reviewed for specialty consul with no outstanding referrals noted. All resident's BM recowere reviewed. Those reside who had not had a BM within last 3 days received laxative according to facility policy wit results. III. The policy for	s had s. II. ts rds nts the	07/16/2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UQNE11 Facility ID:

001145

If continuation sheet

Page 10 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155616	B. WIN			06/17/20	011
			B. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			201 E E			
LANDMA	ARK NURSING AND	REHABILITATION		1	LBANY, IN47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	15. (Resident #8)			Physician Notification and Bl	M	
					Protocol were reviewed and	.	
	Findings include:				found to be appropriate by C		
					Committee. A policy for Phys Referrals was drafted and fo		
					to be appropriate by QA	unu	
	A The climical m	so and for Dogidant 456			Committee. All nurses will be	.	
		ecord for Resident #56			educated on Physician Refe		
		6/14/11 at 1:25 p.m.			Policy, Physician Notification	1	
		agnoses included, but			Policy and BM protocol. IV.		
	were not limited				Director of Nursing or design		
	amputation and fracture distal second,				will review telephone orders to identify outstanding special		
	third, fourth, and	fifth metatarsals of			referrals. Director of Nursing		
	uncertain age. T	he resident had an X-ray			designee will review		
	of the right foot of	completed on 5/24/11.			documentation for those		
		ncluded, but was not			residents with specialty refer	rals	
	1 1	ares of the distal second,			to assure proper physician		
		fifth metatarsals." On	notification and follow up. Director				
	l '				of Nursing or designee will re BM monitoring records daily		
	_	to the physician on			identify any resident who has		
	_ ^	.m., was a note faxed			had a BM in last three days.		
	_	ysician "refer to ortho"			Identified residents will be pl	aced	
	" '	e physician on 5/24/11 at			on a log. Nurses will be instr		
	1923 (7:23) p.m.				to follow BM protocol. Direct		
					Nursing or designee will revi	ew	
	In interview with	the Director of Nursing			log daily to assure proper following of BM protocol. Dire	ector	
	on 6/14/11 at 2:1	0 p.m., she indicated she			of Nursing or designee will re		
		consult and remembered			audit findings to QA monthly		
		No documentation was			three months and quarterly,		
		sult being obtained.			thereafter.V. Date of Comple	etion:	
		vas lacking of the referral			July 16, 2011		
		6/16/11 at 2:40 p.m., the					
	•	•					
	1	ovided a Telephone					
		the ortho referral."					
		at 1615 (415) p.m. the					
	clinical record for Resident #8 was						
	reviewed. The re	esident's diagnoses					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155616	B. WIN			06/17/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		201 E E			
LANDMA	ARK NURSING AND	REHABILITATION		1	LBANY, IN47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	-	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	included, but were not limited to;						
	Alzheimer's dise	ase, hypertension,					
	dementia, cerebral vascular accident (stroke), and constipation.						
		1615 p.m. [4:15 p.m.] the					
		sheet for May 2011 was					
	reviewed. Resid	ent # 8 had not had a					
	bowel movemen	t from the night of					
	5/8/2011 to the r	night of 5/14/2011, 6 days					
	total and did not	have another until					
	5/23/2011, 8.5 days total.						
	On 6/13/2011 at	1615 p.m. [4:15 p.m.] the					
		cation Record indicated					
	1 -	ia Suspension take 30 cc					
	"	rs) by mouth once daily					
	,	nstipation was ordered on					
		continued on 3/25/11.					
	,	magnesia) Give 30 cc po					
	1	PRN (as needed)					
	_	(related to) narcotic					
	ordered 4/6/11 w	as discontinued.					
	On 6/15/2011 at	09:45 a.m. review of the					
		ement of Constipation					
	1	indicated, but was not					
		the policy of this facility					
		s to maintain normal					
		ts, at least 3 times per					
		ng less than 25% of the					
		ty defines constipation as					
	-	er bowel movements per					
	week. The Proce	dure indicates "it shall be					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPL		
1111212111	or conditions	155616	A. BUII			06/17/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			201 E E			
LANDMA	RK NURSING AND	REHABILITATION	NEW ALBANY, IN47150				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		of the charge nurse for	 	1710			DATE
		itor the documentation of					
		ts every shift", "the Day					
		rse for each unit will					
	_	ative list for any resident					
	•	a BM in 3 days", "The					
		arse will offer the PRN					
	_	esident who is on the					
	laxative list", if t	he resident has not had a					
	BM within 24 ho	ours after receiving the					
	PRN (or refusal of	of the laxative), a Fleets					
	Enema may be o	ffered/given if ordered by					
		not ordered, then the					
		be contacted for further					
		esident has not had a BM					
	_	ove interventions, the					
	physicians shoul	d be contacted".					
		09:45 a.m., the Assistant					
		ing (ADON) indicated					
	that they follow t	• •					
	procedure relatin	g to constipation.					
	3.1-35(g)(2)						
F0309 SS=D	must provide the r to attain or mainta physical, mental, a in accordance with assessment and p						
	Based on record	review and interview,	F0	309	I. R8's BM pattern is being		07/16/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155616		LDING	00	06/17/2	
		100010	B. WIN		ADDRESS CITY STATE TINCODE	00/11/2	011
NAME OF	PROVIDER OR SUPPLIEI	₹		201 E E	ADDRESS, CITY, STATE, ZIP CODE		
LANDMA	ARK NURSING AND	REHABILITATION		1	LBANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	+	TAG	monitored and she has had a	-4	DATE
	the facility failed to monitor the residents bowel movements, provide medication				least one BM every 3 days. I		
		• •			resident's BM records were	,	
		nysician related to the			reviewed. Those residents w	ho	
	_	constipation for 1 of 2			had not had a BM within the		
		ed for constipation in a			days received laxative accor to facility policy with results.		
	sample of 15. (I	Resident #8)			The BM Protocol was review		
	Findings include	y:			and found to be appropriate QA Committee. All nurses wi educated on BM protocol. IV	by II be	
	On 6/13/2011 at	1615 [4:15 p.m.] the			Director of Nursing or design		
		or Resident #8 was			will review BM monitoring re-		
		resident's diagnoses			daily to identify any resident		
		ere not limited to;			has not had a BM in last thre days. Identified residents wil		
	· ·				placed on a log. Nurses will l		
		pertension, dementia,			instructed to follow BM proto		
		r accident (stroke), and			Director of Nursing or designee will review log daily to assure proper following of BM protocol.		
	constipation.						
	0 (/12/2011	1615 m m 4h 2 DM			Director of Nursing or design		
		1615 p.m. the BM t for May 2011 was			will report to QA Monthly for		
		lent # 8 had not had a			months and quarterly, therea		
					V. Date of Completion: July 2011	16,	
		t from the night of			2011		
		night of 5/14/2011, 6 days					
		have another until					
	5/23/2011, 8.5 d	ays total.					
	On 6/13/2011 at	1615 p.m., [4:15 p.m.]					
		ledication Record					
	1						
		of Magnesia Suspension					
	,	c centimeters) by mouth					
	1	eded for constipation was					
	ordered on 09/19/08 and discontinued on 3/25/11. MOM (milk of magnesia) Give						
	1	uth) daily PRN (as					
	needed) constipa	ation R/T (related to)					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155616	B. WIN			06/17/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		201 E E			
LANDMA	ARK NURSING AND	REHABILITATION			LBANY, IN47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	· E	DATE
	narcotic ordered	4/6/11 was discontinued.	1				
	On 6/15/2011 at	09:45 a.m. review of the					
	facilities Management of Constipation						
	undated policy i	ndicated, but was not					
	limited to; "it is	the policy of this facility					
	to assist resident	s to maintain normal					
	bowel movemen	ts, at least 3 times per					
	week with staini	ng less than 25% of the					
	time." The facili	ty defines constipation as					
		er bowel movements per					
	week. The Proce	edure indicates "it shall be					
	the responsibility	y of the charge nurse for					
		itor the documentation of					
	bowel movemen	ts every shift", "the Day					
		rse for each unit will					
	1	ative list for any resident					
		a BM in 3 days", "The					
		urse will offer the PRN					
	_	esident who is on the					
	I -	the resident has not had a					
		ours after receiving the					
		of the laxative), a Fleets					
	,	offered/given if ordered by					
	1	not ordered, then the					
		be contacted for further					
		esident has not had a BM					
		ove interventions, the					
	physicians shoul						
	FJ2						
	On 6/13/2011 at	09:45 a.m. Assistant					
	Director of Nurs	ing (ADON) indicated					
		policy and procedure					
	relating to consti						
	I remains to consti	punon.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPL	ETED
		155616	B. WING			06/17/2	011
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN47150				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	T	ГAG	DEFICIENCY)		DATE
F0312 SS=D	A resident who is of daily living rece to maintain good repersonal and oral Based on observer record review, the provide personal the facility policy for 2 of 5 incontain a sample of 15 observed for inconsupplemental sar 8, 24, 37) Findings include 1. On 06/13/11 and Nursing Assistant observed to prove Resident # 24. The transferred from the brief was rempasty stool was on her	unable to carry out activities lives the necessary services nutrition, grooming, and hygiene. ation, interview, and refacility failed to hygiene as outlined in resident sobserved and 1 of 1 resident resident ontinence care in a mple of 7. (Residents' #	F031		I. R24, R8 and R37 were assessed by licensed nurse a found to be clean and free fro adverse outcomes related to identified practices. II. All residents who are dependent upon staff to provide perineal care were identified through review of MDS data. All ident residents were assessed and found to be clean and free frosigns/symptoms of adverse outcomes related to perineal care. III. The facility's policy found appropriate by QA Committee. Senior C.N.A. Me will be reeducated on Perineal Care by Director of Nursing of designee and return demonstration will be conduct to assure competency. All C. s will be reeducated on perin care and return demonstration will be conducted by Senior C.N.A. Mentor. IV. The Director C.N.A. Mentor. IV. The Director of Nursing Co.N.A. Mentor. IV. The Director C.N.A. Mentor. IV. The Director C.N	om t I iffied d om for and entor al or eted N.A.' eal ons	07/16/2011
	CNA #1 wiped tl	resident two hours prior. ne front of the resident en her legs using three			Nursing or designee will concrandom audits of perineal carx's weekly for 2 weeks, week 2 weeks, and monthly for 2	re 2	

001145

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155616	A. BUI	LDING	00	06/17/2011
		133010	B. WIN			00/1//2011
NAME OF I	PROVIDER OR SUPPLIER			201 E E	ADDRESS, CITY, STATE, ZIP CODE	
LANDMA	RK NURSING AND	REHABILITATION		1	LBANY, IN47150	
(X4) ID		TATEMENT OF DEFICIENCIES		ID		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	wash cloths. The	e CNA looked in the			months. The results of these	
	closet and 1 draw	ver for clean briefs using			audits will be reported to QA	
	the same gloves i			Committee monthly for three months and quarterly,		
	the resident. A c	lean brief and pants were			thereafter.V. Date of Comple	etion:
	applied using the	soiled gloves used to			July 16, 2011	
	clean stool. The	CNA failed to separate				
	the labia, or clear	nse the vaginal area.				
	2 0 6/15/11	0.52 D 1 110				
		8:52 a.m., Resident #8,				
	1	in a reclining geri chair				
	1	m for the 100, 200, and 52 a.m. Certified Nursing				
		#3, was observed to take				
	the resident to he					
	the resident to he	1 100111.				
	The CNA #3 who	en queried at that time,				
	indicated that the	night shift had gotten				
	the resident out o	of bed before ending their				
	shift at 6:00 a.m.	She further indicated				
	she had not chan	ged the resident since she				
	came on duty at 6	6:00 a.m.				
	A4 0.52	TA //21				
	l '	NA #3 placed a gait belt				
		ent's waist and transferred				
	her from the chai					
		A #3 left the room to ns. Upon return she				
		nd removed peri wash				
	I -	awer and sprayed the peri				
		h. She removed the				
		ants and brief. The brief				
	1	urine. CNA #3 wiped the				
		he cloth, turned the				
	_	he window and using a				
	resident toward t	he window and using a				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155616	B. WIN			06/17/2011
NAME OF E	PROVIDER OR SUPPLIER	!!		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SOLI EIER			201 E E	ELM ST	
LANDMA	ARK NURSING AND	REHABILITATION		NEW A	LBANY, IN47150	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	1 -	ed a small smear of stool				
	from the anal area. Without washing her					
	hands or removing her gloves she again					
	opened the dress	er drawer. She indicated				
	she was looking	for cream to apply to the				
	resident's buttock	KS.				
	At 10:02 a m C	NA #2 romoved her				
		NA #3 removed her				
	1 -	out handwashing left the				
		ream from the supply				
	_	urn, she donned gloves				
		shing and put the "skin				
	1 ~	" on the resident's				
		3 applied a clean brief,				
	1 .	gen canula, sheet and				
	_	ut removing the soiled				
	gloves or washin	g her hands.				
	 At 10:08 am th	e CNA #3, removed her				
		ed her hands. She failed				
	l =	the resident's legs, or				
		to wash the urine from				
	the resident's skir					
	the resident's SKI	п.				
	On 06/16/11 at 2	:41 p.m., the Assistant				
		ing provided the facility's				
	Procedure for Pe	0 1				
		cedure was the same as				
	1	Department of Health				
	Standards.	Department of Housen				
	Sundinus.					
	The procedure in	dicated the following:				
		•				
	Bullet 3. Assist	resident to supine				

001145

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155616	A. BUI	LDING	00	COMPLE 06/17/20	
		100010	B. WIN			00/17/20	711
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ΙΔΝΠΜΔ	ARK NURSING AND	REHARII ITATION		201 E E	LBANY, IN47150		
					LB/1141, 114+7 100		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	DATE
_	position.	,		_			
	l ^	vaterproof pad under the					
	resident's hips.	vaterproof pad under the					
	Billet 5. Drape r	esident					
	Bullet 6. Fill wa						
	and have residen						
	temperature.	t chicon water					
	Bullet 7. Put on	gloves					
		resident to spread legs					
	and lift knees if p	, .					
	1 *	d soap folded washcloth					
		from front to back and					
	•	erineum to thighs.					
	_	th as necessary for					
	females.	iii as necessary for					
		te labia. Wash urethral					
	area first	to ration. Washing around					
		etween and outside labia					
		okes, alternating from					
		noving outward to thighs.					
		art of washcloth for each					
	stroke.						
	On 06/17/11 at 1	0:25 a.m., the Senior					
		vided copies of the skills					
	1	CNA #'s 1, 2, 3, and 4.					
		above CNA's skills were					
		re and again on 04/14/11.					
	1 ^	e repeat skills check was					
		ure all CNAs were					
	competent in care						
	On 06/17/11 at 1	0:45 a.m., the skills					
		Senior CNA Mentor					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155616	B. WING		06/17/2011
NAME OF P	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	-!
TO THE OF T	KOVIDEK OK SOTTEIEF		201 E E		
LANDMA	RK NURSING AND	REHABILITATION	NEW A	LBANY, IN47150	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	_	leted on 04/13/11 was			
	reviewed.				
	All CNAs including the mentor were				
	checked off as co	ompetent in incontinence			
	care.				
	3. During obse	rvation on 6/16/2011 at			
	08:50 a.m.,. Cert	tified Nursing Aide			
	(CNA) # 4 perfo	rmed peri care on			
	Resident # 37. C	NA # 4 entered the			
	resident's room a	and asked Resident # 37			
	if it was ok if she	e did her peri care. CNA#			
	4 applied a gait b	pelt to resident # 37 and			
	walked her to the	e bathroom. CNA # 4			
	washed hands an	nd applied gloves and then			
		on the toilet. CNA #4			
	prepared plastic				
		ying soap to 1 washcloth.			
		the resident to stand up			
		e bar. The CNA stood			
	_	ent and used the cloth			
		g front to back swiping 2			
		used the rinse cloth			
	•	e. The CNA patted the			
		•			
	-	owel and pulled the brief oved the gloves and			
		oved the gloves and all walked resident back to			
		iu waikeu iesiuent dack to			
	bed.				
	2.1.20(-)(2)(4)				
	3.1-38(a)(3)(A)				
					l

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UQNE11 Facility ID:

001145

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155616	1 ' '			06/17	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODI		
NAME OF I	PROVIDER OR SUPPLIER			201 E E		•	
	ARK NURSING AND	REHABILITATION			LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC		(X5)
	``				CROSS-REFERENCED TO THE APPR		
F0323 SS=E	The facility must e environment rema hazards as is poss receives adequate devices to prevent Based on observarecord review, the hazardous materiproperly on 1 of deficient practice affect 5 residents in a census of 15 [Residents' # 1, 2]. Findings include: 1. On 06/13/11 athe Certified Nur 100 Hall was unl. The following ite. 1. Evoke Total Elli bottles. The Material Safe by the Assistant I (ADON) at 3:45 following under Ite. Eye contact: Determine the property of the prop	cy MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) Insure that the resident ins as free of accident sible; and each resident expervision and assistance accidents. Intion, interview and efacility failed to ensure als were secured in the survey days. This is that the potential to indentified with dementia in the potential to indentified with demential to indentified with dementia in the potential to indentified with demential to indentified with dem	F0	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	oly closet II. I assure ocked. III. ed on the t storage mes. IV. signee will daily o assure ee will o QA ad Date of	(X5) COMPLETION DATE 07/16/2011
	Ingestion: Do no	ot induce vomiting.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155616		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/17/2	ETED	
NAME OF I	DROVADED OD GUIDDI IEI		B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIEF			201 E E			
		REHABILITATION			LBANY, IN47150		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	Contact a physic Center.	ian or Poison Control					
	2. Nightingale Perineal Wash 1 bottle.						
	The Material Sa	fety Data Sheet, provided					
	1 *	ndicated the following					
	under First Aid I	Measures:					
	Eye Contact: Do not rub eyes. Flush eyes thoroughly with water for 15 minutes. If condition worsens or irritation persists, contact physician. Ingestion: Do not induce vomiting. Contact a physician or Poison Control Center.						
	Lotion 6 bottles. The Material Sa	fety Data Sheet provided dicated the following					
	thoroughly with	o not rub eyes. Flush eyes water for 15 minutes. If ns or irritation persists, n.					
	Contact a physic Center.	ot induce vomiting. ian or Poison Control					
	4. Zinc Oxide C	Dintment 20 packets.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155616	B. WIN	IG		06/17/2011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
LANDMA	RK NURSING AND	REHABILITATION		201 E E NEW AL	_BANY, IN47150	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
	The Material Saf	Eety Data Sheet provided				
	•	dicated the following				
	under the First Aid Measure Section.					
	Eyes: Flush eyes with plenty of water for at least 15 minutes.					
	Ingestion: If swa	allowed, get medical help				
	-	on Control Center right				
		e anything by mouth to				
	an unconscious p	person.				
	5. Razors 29.					
	On 6/13/11 in int	erview with the unit				
		p.m., she indicated the				
		sed to be kept locked				
		not in attendance. 5 unit were identified				
		a census of 15 residents				
		lents' # 1, 2, 4, 11, & 12]				
	3.1-45(a)(1)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155616		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING (X3) DATE SURV COMPLETE 06/17/2011			LETED		
		155010	B. WIN			00/11/2	.011
NAME OF I	PROVIDER OR SUPPLIER			201 E E	ADDRESS, CITY, STATE, ZIP CODE		
LANDMA	ARK NURSING AND	REHABILITATION		1	LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
F0328 SS=D	proper treatment a special services: Injections; Parenteral and enterior Colostomy, ureter Tracheostomy care; Tracheal suctionin Respiratory care; Foot care; and Prostheses. Based on record observation, the their policy and prosthese flushing of periple catheter (PICC) I standard precauti reviewed with a standard precauti reviewed with a standard precauti reviewed. The resinculated, but we below knee ampures istant staphylorelated to left stuintravenous antib peripheral inserted. On 6/14/2011 at observation LPN #56's room applies.	review, interview and facility failed to follow procedure related to heral inserted central lines and maintaining fons for 1 of 1 resident PICC line in a sample of 6): 1430 [2:30 p.m.] the per Resident # 56 was resident # 56 was resident's diagnoses re not limited to: left latation, methicillin procedure (MRSA) and receiving protection therapy through a red central catheter. 1300 [1:00 p.m.] upon with a line of the side	F0	328	I. Resident #56 was assessed and found to have no signs/symptoms of adverse outcomes related to identified practice. II. All residents were reviewed for the presence of PICC lines. No other resident identified. III. LPN #1 was suspended from further resident care until redemonstration of medication administration via PICC lines completed correctly. The fact policy for Medication Administration via PICC lines reviewed and found to be appropriate by QA Committee nurses will be educated on medication administration via PICC line. IV. The Director of Nursing or designee will concrandom audits of medication administration via PICC line weekly for four weeks and the monthly for 2 months. The resident of these audits will be reported QA Committee monthly for 3 months and quarterly, thereafter.V. Date of Complet July 16, 2011	d e e t was dent ed to eturn was ility's was e. All a f duct en esults ed to	07/16/2011
	reviewed with a last 15. (Resident #56 Findings include On 6/14/2011 at clinical record for reviewed. The residual included, but were below knee ampuresistant staphylorelated to left stuintravenous antibiperipheral inserted On 6/14/2011 at observation LPN #56's room applied.	PICC line in a sample of 6) : 1430 [2:30 p.m.] the or Resident # 56 was esident's diagnoses re not limited to: left attation, methicillin occocal aureus (MRSA) mp and receiving photic therapy through a ed central catheter. 1300 [1:00 p.m.] upon N #1 entered resident			identified. III. LPN #1 was suspended from further resident can and was not permitted return to resident care until redemonstration of medication administration via PICC lined completed correctly. The fact policy for Medication Administration via PICC lined reviewed and found to be appropriate by QA Committed nurses will be educated on medication administration via PICC line. IV. The Director of Nursing or designee will control administration via PICC lined weekly for four weeks and the monthly for 2 months. The resident of these audits will be reported QA Committee monthly for 3 months and quarterly,	dent ed to eturn was ility's was e. All a f duct en esults ed to	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE :	ETED	
		155616	B. WIN	G		06/17/2	011
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A 201 E E	ADDRESS, CITY, STATE, ZIP CODE		
	ARK NURSING AND			1	LBANY, IN47150		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ.	COMPLETION DATE
		abing. In the process of					
	spiking the media						
	end of the tubing	, which did not have an					
	end cap on it, on	the floor. She					
	immediately pick	ted it up and placed the					
	_	m pump (automatic					
	1	nser) and then connected					
		oing to the PICC line.					
		se alcohol swabs or ytime during the process					
		ng that had fallen on					
	floor.	ing that had fairch on					
	11001.						
	On 6/14/11 at 2:	45 pm., the DoN					
	provided the faci	-					
	Procedure for the	e flushing of PICC lines					
	which indicated,	but was not limited to;					
	· ·	roughly clean injection					
	_	ol swab, attach saline					
	' -	, clean injection port					
	-	ol swab, aseptically					
		ibing or syringe with					
	administration of	e injection port and begin					
	aummistration of	IIIIuSIOII					
	On 6/17/2011 at	09:50 a.m. in an					
		e Administrator she					
	indicated that LP	N # 1 had been trained in					
	the care of PICC	lines and infection					
	control.						
	0 6/17/2011	00.50					
		09:50 a.m. record review					
		ills validation checklist					
	IOT LPN # I INCIO	cated the PICC care and					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155616	B. WIN			06/17/2	011
NAME OF B	DOLUBER OR GURRI IER				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	<u>.</u>		201 E E	ELM ST		
	RK NURSING AND				LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſΕ	COMPLETION DATE
IAG			-	IAG			DATE
		was completed on					
	4/12/2011.						
2.1.45(.)(2)							
	3.1-47(a)(2)						
70071	The feetility was at						
F0371 SS=F	The facility must -	rom sources approved or					
33-r		ctory by Federal, State or					
	local authorities; a						
		, distribute and serve food					
	under sanitary con		F0	271	I. The 3 door refrigerator was	_	07/17/2011
		ation and interview, the	10	371	cleaned. All undated food ite		07/16/2011
	_	ensure staff washed their			were discarded. The food sli		
		t was clean, food			was cleaned. Food temperat		
	•	re recorded, and food was			are being recorded prior to e		
		ded after three days for 1			meal service. The microwave oven was cleaned. The floor		
		rvations. This deficient			were removed and are no lo		
		potential to affect 66 of			stored with food items. The		
	66 health center i	residents.			gasket on the chest freezer		
					repaired. Plastic tubs and ute were cleaned. The container		
	Findings include	:			were cleaned. Covers were	iius	
	0.06/45/45				placed over the lights above		
		ween the hours of 11:49			storage area for steam table	•	
	-	the following was			and back door exit. Bowls ar	ıd	
	observed:				cups were cleaned. II. Daily Sanitation Checks were		
					completed to identify any fur	ther	
	1. The 3 door refrigerator was soiled with				kitchen sanitation issues. No	ne	
	a sticky orange substance on the floor of the refrigerator.2. A. Seven peanut butter and jelly sandwiches on a plate lacked a date. The			were identified. III. Dietary A			
				#1 was reeducated on prope food handling and hand was			
				Dietary cleaning schedules a			
				Daily Rounds form were draf	ted		
				and approved by QA Commi			
Dietary Manager indicated everything				All dietary employees will be			

´		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155616	B. WIN			06/17/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LANDMAA	DIC NUI IDCINIC AND			201 E E			
	RK NURSING AND			INE VV AI	LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·		IAU	reeducated on proper food		DATE
	should be dated and be discarded after				storage and labeling, proper		
	three days.				cleaning techniques, proper	ood	
	_	s with tomato slices			handling, hand washing and		
	without a date.	ee salads without a date.			time temperature recording. The Dietary Supervisor or	IV.	
					designee will conduct daily a	udits	
	D. A containe without a date.	er of fruit cocktail			of food storage, food labeling		
		ntain an af fmit1-t-:1			food temperature logs and		
	_	ntainer of fruit cocktail			sanitation of dietary departm The results of these audits w		
	dated 5/25/11.	and of nottons of the			reported to QA weekly for for		
		nes of cottage cheese			weeks, monthly for two month		
	without a date.				and quarterly thereafter. V. I		
	_	mall dishes of applesauce			of Completion: July 16, 2011		
	without a date.	C) (1 :					
		er of Mandarin oranges					
	lacked a date.						
	2 The food slips	er was soiled with dried					
		Dietary Manager					
	before.	ast used the evening					
	delore.						
	1 Food tompore	tures for the breakfast					
	•	corded at 11:50 a.m. In					
		the cook, at this time, she					
		k them but failed to					
	record them.	k mem but famed to					
	record them.						
	5 The microscop	ve oven was soiled on the					
	inner surface with substance.	ii a sucky biowii					
	substance.						
	6 Two rubbor fl	oor mats were rolled up					
		the prep counter. The					
	Dietary Manager	indicated the mats were					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	I DING	00	COMPLETED	
		155616	B. WIN			06/17/2011	
			p. ,,		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			201 E E			
LANDMA	RK NURSING AND	REHABILITATION		1	LBANY, IN47150		
(X4) ID	CHMMADVC	TATEMENT OF DEFICIENCIES		ID	,	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	J
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	`
	placed on the shelf when the floor was			0		3.112	
	•						
		ning. Packages of Kool					
	_	ags were also stored on					
	the shelf.						
	_	the chest freezer was					
		tely 12 inches in one area					
	and 2 inches in a	second area.					
	8. Plastic tubs w	rith utensils stored in					
	them were soiled	with food crumbs/debris					
	on the inner surfa	aces.					
	011 0110 111101 50111						
	9 The lids of the	e containers for sugar and					
		ere soiled with a sticky					
	substance.	cie solied with a sticky					
	substance.						
	10 Diatama aida	#1 alasamad 4a dasa					
		#1, was observed to drop					
		n the floor and lifted the					
		an with bare hand and					
	disposed of the n	nargarine. She continued					
	to prepare the tra	ys for lunch without					
	washing her hand	ds.					
	11. The ceiling l	ights in the storage area					
	_	ans and the back door					
	exit lacked a cov						
	CAIT INCKOM W COV	V 1.					
	 12 Eleven of six	xteen bowls stored as					
		d with food debris on the					
		i with 1000 deolis on the					
	inner surfaces.						
	_	een cups stored as clean					
	were soiled with	food debris on the inner					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2011 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155616	A. BUILDING B. WING		06/17/2011	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	I	
				ELM ST		
	RK NURSING AND			ALBANY, IN47150		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	, i	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	surfaces.					
	3.1-21(a)(2)					
	3.1-21 (i)(3)					
F0411	The facility must a	ssist residents in obtaining				
SS=D	•	ur emergency dental care.				
	A facility must prov	vide or obtain from an				
	outside resource,	in accordance with				
	§483.75(h) of this	part, routine and services to meet the needs				
	• •	nay charge a Medicare				
	resident an addition	onal amount for routine and				
	emergency dental	services; must if the resident in making				
	appointments; and					
	transportation to a	nd from the dentist's office;				
	and promptly refer damaged dentures	residents with lost or				
	_	review and interview, the	F0411	I. R51 is schedule to see ora	07/16/2011	
		follow up in a timely		surgeon on July 7, 2011II. A residents with dental referra	I	
		tist's referral for 1 of 15		at risk to be affected. All res		
		ed for dental services to		records were reviewed and	no	
	_	on in a sample of 15		outstanding referrals were n III. A policy for Physician	oted.	
	residents. (Residents)	ent #51)		Referrals was drafted and fo	ound	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		155616	B. WIN			06/17/20	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			201 E E			
LANDMA	ARK NURSING AND	REHABILITATION			LBANY, IN47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TΕ	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		_	TAG			DATE
TAG	Finding includes Review of the cli #51 on 6/14/2011 the resident had of included, but were dependent diabet heart disease, congastroesophageal On 4/11/2011, the visited and made and recommendate and recommendate area 4 x [by] 5 m right lateral tongs surgeon: right lateral tongs surgeon: right lateral tong surgeon: right lateral tong surgeon: right lateral tong surgeon: right lateral tong surgeon by the social [name of oral surgeon have been been been been been been been be	inical record for Resident I at 1:50 p.m., indicated diagnoses which re not limited to, insulin res mellitus, coronary regestive heart failure, and I reflux disease. e consultant dentist the following notations ation: "Mixed red/white am [millimeter] irregular rue. Referral to oral reral tongue area - for evaluation". e at the bottom of this al worker "Call placed to regeon]. He will be in to on May 3rd between ration was lacking of the ring made the visit on iew with the social 2011 at 11:00 a.m., she I surgeon had come in on		TAG	to be appropriate by QA Committee. All nurses will be educated on Physician Refel Policy. IV. Director of Nursing designee will review telephor orders daily to identify outstanding specialty referra Director of Nursing or design will review documentation for those residents with specialty referrals to assure proper scheduling and follow up. Dir of Nursing or designee will re audit findings to QA monthly three months and quarterly, thereafter. V. Date of Comple July 16, 2011	errals g or ne ls. nee r y rector eport for	DATE
	l	- but because the resident					
	_	at the time, he did not					
		m and indicated he					
	would be back as	s he had other patients to					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616			(X2) MULTIPLE CC A. BUILDING B. WING	00	li i	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER	REHABILITATION	STREET A 201 E E	ADDRESS, CITY, STATE, ZIP ELM ST LBANY, IN47150	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	not followed up appointment unt	vorker indicated she had to make another il it was brought to her y - 6 weeks after the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155616		(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE S COMPL 06/17/2	ETED		
		133010	B. WING			00/17/2	011	
NAME OF F	PROVIDER OR SUPPLIER			201 E E	DDRESS, CITY, STATE, ZIP CODE			
LANDMA	RK NURSING AND	REHABILITATION			_BANY, IN47150			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE	
F0441 SS=D	Infection Control F a safe, sanitary an and to help prever	stablish and maintain an Program designed to provide ad comfortable environment at the development and sease and infection.						
	Program under wh (1) Investigates, coinfections in the fa (2) Decides what pisolation, should bresident; and (3) Maintains a recorrective actions (b) Preventing Spr (1) When the Infect determines that a prevent the spread must isolate the recorrective must isolate the recorrective must isolate the recorrective must isolate the recorrective actions.	stablish an Infection Control nich it - ontrols, and prevents cility; orocedures, such as e applied to an individual cord of incidents and related to infections. read of Infection ction Control Program resident needs isolation to d of infection, the facility						
		contact with residents or contact will transmit the						
	disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.							
		andle, store, process and as to prevent the spread of						
	A. Based on record review and interview,	F04	441	I. Resident 20 and 11 have		07/16/2011		
	the facility failed	to ensure newly			received initial PPD and will			
	admitted resident	ts received a tuberculin			receive 2nd step according to facility policy. Resident #56 v			
	skin test upon ad	mission for 2 of 3 newly			assessed and found to have	•		
	•	ts reviewed in a sample			signs/symptoms of adverse			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155616	B. WIN			06/17/2	011
			-		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	£		201 E E	ELM ST		
	ARK NURSING AND	REHABILITATION			LBANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG			DATE
	of 15. (Resident	s' #11, 20)			outcomes related to identified practice. II. All resident recor		
					were reviewed for the preser		
	B. Based on reco	ord review, interview and			documented 2 step PPD upo		
	observation, the	facility failed to ensure			admission. Those residents		
	Standard and Co	entact Precautions were			without documentation of 2 s	tep	
	followed accordi	ing to facility policy and			PPD will have initial PPD		
		of 2 residents reviewed			administered and then 2nd s		
	1 ^	change in a sample of 15.			according to facility policy. A residents were reviewed for		
	(Resident #56)	and ge in a sumpre of te.			presence of PICC lines. No o		
	(Resident #30)				resident was identified. All		
	Findings include				residents with wounds were		
	Findings include	·			identified. All wounds were		
					assessed by licensed nurse	and	
		al record for Resident #11			none found to show signs/symptoms of adverse		
		6/14/11 at 12:25 p.m.			outcomes related to dressing	1	
		agnoses included, but			changes. III. The facility's po		
	were not limited	to Parkinson's disease			on PPD administration upon	Í	
	and immobility s	syndrome. The resident			admission was reviewed and		
	was admitted to	the facility on 6/9/11.			found to be appropriate by Q		
	The first step PP	D (purified protein			Committee. All nurses will be reeducated on PPD	;	
	derivative) was a	administered on 6/11/11			administration requirements	upon	
	as documented o	on the June 2011			admission. A Nurse's Admiss		
	Medication Adm	ninistration Record.			Checklist and an IDT Admiss	ion	
					Checklist were developed the		
	A 2 The clinic	al record for Resident #20			include admission PPD. LPN	#1	
		16/14/11 at 9 a.m. The			was suspended from further resident contact and was not		
		ses included, but were			permitted to return to resider		
	1	mentia and diabetes			care until return demonstration		
					medication administration via		
		sident was admitted to the			PICC line and clean dressing		
	facility on 6/7/11. The first step PPD was				change was completed corre	ctly.	
	administered on	6/13/11.			The facility's policies for Medication Administration via	,	
					PICC line and clean dressing		
	On 6/15/11 at 2:2	25 p.m., in interview with			change were reviewed and for		
	the Director of N	Jursing, she indicated the			to be appropriate by QA		
	PPD was due wi	thin 24 hours of			Committee. All nurses will be	•	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE: COMPL 06/17/2	ETED	
	ROVIDER OR SUPPLIER	REHABILITATION	•	201 E E	DDRESS, CITY, STATE, ZIP CODE LM ST BANY, IN47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	clinical record of reviewed. The re- included, but we below knee amporesistant staphylo- related to left stu- intravenous antib- peripheral inserted. During observation p.m. the Licensed 1 failed to maintage	11 at 2:30 p.m. the f Resident # 56 was esident's diagnoses re not limited to; left utation, methicillin ococcal aureus (MRSA) amp and receiving biotic therapy through a ed central catheter. on on 6/14/2011 at 1:00 d Practical Nurse (LPN) # tain Standard Precautions are Peripheral Inserted (PICC) and			reeducated on medication administration via PICC line clean dressing change. IV. T admitting nurse, 1st nurse to follow admit and 2nd nurse to follow admit will review and soff on Admission Checklist. Director of Nursing or design will review Nurses Admission Checklist, new admit clinical records and record findings of IDT Admission checklist with hours of admission. The Director of Nursing or designee will conduct random audits of medication administration via PICC line and clean dressing changes weekly for four week and then monthly for 2 monto The results of these audits were ported to QA Committee monthly for 3 months. V. Data Completion: July 16, 2011	The	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155616	A. BUI	LDING	00	06/17/2	
		133010	B. WIN			00/17/2	011
NAME OF I	PROVIDER OR SUPPLIER			201 E E	ADDRESS, CITY, STATE, ZIP CODE		
LANDMA	RK NURSING AND	REHABILITATION			LBANY, IN47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	-	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE.	DATE
	administering int	ravenous antibiotic. LPN					
	#1 failed to follo	w facility policy and					
	procedure for the	flushing of PICC lines					
	which indicated,	but was not limited to;					
	"wash hands, tho	roughly clean injection					
	ports with alcoho	ol swab, attach saline					
	syringe and flush	, clean injection port					
	again with alcoho	ol swab, aseptically					
	attach infusion tu	bing or syringe with					
	medication to the	e injection port and begin					
	administration of	infusion". LPN #1					
	entered the room	applied gloves and					
	mixed the antibio	otic medication then					
	spiked bag and p	rimed tubing. In the					
	process of spikin	g the medication she					
	dropped the end	of the tubing, which did					
	not had a end cap	on it, on the floor. She					
	immediately pick	red it up and placed					
	tubing in Plum p	ump (automatic					
	medication dispe	nser) and then connected					
	end of the tubing	to the PICC line. LPN					
	#1 did not use ald	cohol swabs or wash					
	hands at anytime	during the process and					
	used the tubing tl	hat had fallen on floor.					
	LPN # 1 then pro	oceeded with the dressing					
	change as describ	ped below without					
	removing gloves						
	On 6/14/2011 at	1:50 p.m. Licensed					
	Practical Nurse (LPN) # 1 was observed					
	with gloves on f	rom the administration of					
	medication previ	ously noted, LPN # 1					
	removed the boo	ot posey from the right					
	foot, she then ren	noved three old dressings					

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PRINTED: 07/11/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE COMPI	ETED	
		155616	B. WIN			06/17/2	011
	PROVIDER OR SUPPLIER		'	201 E E	DDRESS, CITY, STATE, ZIP CODE LM ST LBANY, IN47150	•	
		TATEMENT OF DEFICIENCIES		ID			(V.5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	on right shin, toe	and heel with scissors	ľ	ĺ			
	taken from her p	ocket. She washed right					
	shin, right second	d toe and right heel with					
	normal saline and	d applied a 6 x 3 pad to					
	shin and 2 x 2 ga	uze to second toe, she					
	then used the san	ne scissors, which she					
	used to remove the	he dirty dressing, to cut a					
	piece of mepilex	(spongy dressing) and					
	applied to right h	neel. LPN # 1 removed					
	•	ed new gloves and then					
		rlix (long gauze dressing)					
	_	up to shin. LPN # 1					
		g from the left stump and					
		oves and put on new					
	-	s noted on stump, # 1					
		n inner right of stump					
		1 on right inner thigh just					
		I # 1 placed hydrogel on a					
	· ·	tick dressing) and					
		1 and with same scissors					
	•	epilex and applied to area					
		56 had a box of elastic					
	_	n that LPN # 1 cut a					
	_	opped on floor, she					
		proceeded to apply over					
	_	stump. LPN # 1 tied up					
		n dirty dressings in it and					
		er supplies on bed and					
		om. LPN # 1 placed left					
		treatment cart, placed					
	_	pocket and took garbage					
	bag to dirty utility room.						
	The Multi Drug	Resistant Organisms					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155616		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/17/2	ETED	
NAME OF PROVIDER OR SUPPLIER			!		DDRESS, CITY, STATE, ZIP CODE		
LANDMA	ARK NURSING AND	REHABILITATION		201 E E NEW AL	LM ST BANY, IN47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Policy provided 2:45 p.m., included 1:45 p.m.,	by RN #1 on 6/14/11 at ded, but was not limited e standard precautions as roach to preventing MDROs [multi drug ms], Caregivers should with soap and water ntact with infected or and before leaving the ntiseptic handwashing roved alcohol-based hand lable, hands should be noving the gloves". 109:50 a.m., in an an and the Administrator she PN # 1 had been trained in the separately on the clinical because she was out the which was on 3/29/2011. 109:50 a.m. record review ills validation checklist cates that PICC care and was completed on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155616 06/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 201 E ELM ST LANDMARK NURSING AND REHABILITATION NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0465 The facility must provide a safe, functional, sanitary, and comfortable environment for SS=D residents, staff and the public. I. Identified gutter was repaired. F0465 07/16/2011 Based on observation and interview, the II. All guttering was inspected and facility failed to ensure the downspout found to be in working order. III. was in good repair and the drain was Gutter inspection was added to clear, during a torrential rain fall during 1 weekly Maintenance Audit. IV. Maintenance Director or designee of 5 days. (June 15, 2011) (Resident #100 will inspect guttering weekly to and 101) assure proper working order. Results of audits will be reported Findings include: to QA monthly for 3 months. V. Date of Completion: July 16, 2011 On 6/15/11 the following was observed: At 8:32 a.m., resident's #100 and 101 were observed seated in the smoking area during a rain. During interview at that time, resident #101 indicated to be careful as rain was dripping from a wire above the door. He indicated some stones had to be placed in a hole near the air conditioner to the dining area, as water would flow off the gutter and the hole continued to expand. At 10 a.m., resident #101 brought an umbrella to the surveyors so as to check out the gutter near the smoke area. At this time, the rain was coming down extremely hard. On nearing the door, the water could be observed pouring like a waterfall from the elbow on the gutter. It was pouring so hard and fast that the drain

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616		A. BUIL	DING	NSTRUCTION 00	(X3) DATE S COMPL 06/17/2	ETED
		B. WING 06/17/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN47150				
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
in the sidewalk we began to accumulate near where 2 resistance interview with that this time, he iman elbow as water roof and the drain 3.1-19(f) The facility must meach resident in accomplete; accurate accessible; and sy The clinical record information to identhe resident's asseand services provipreadmission scressate; and progress Based on record the facility failed progress notes we for 1 of 15 sample notes reviewed. Findings include The clinical record reviewed on 6/13	rould not drain and water late over the sidewalk dents were seated. In the Maintenance Director, dicated the gutter needed or was overshooting the in was not working. The maintain clinical records on excordance with accepted ards and practices that are rely documented; readily stematically organized. The must contain sufficient the tify the resident; a record of ressments; the plan of care ded; the results of any review and interview, to ensure physician review and interview, to ensure physician record residents progress (Resident #20)	F05		I. Resident 18's progress not were placed in medical record and resident's medical records were reviewed for missing progress notes. No missing reference were noted. III. A Physician's Follow Up log was drafted. A nurses were reeducated on the necessity of progress notes the placed in the residents' medical records following a physician IV. The Director of Nursing of	d II. s notes Visit II he o be cal visit.	07/16/2011
				Physician's Visit Follow Up Io	-	
	PROVIDER OR SUPPLIER JUMMARY S' (EACH DEFICIENCY REGULATORY OR In the sidewalk was began to accumulate the sidewalk was accumulated to accumulate the sidewalk was water of and the drain and elbow as water roof and the drain accessible; and synthematical recordinformation to idente the resident's asset and services proving preadmission scressible; and progress and services proving preadmission scressible; and progress and services proving the facility failed progress notes was for 1 of 15 sample notes reviewed. Findings include: The clinical recording the sidematical recor	IDENTIFICATION NUMBER: 155616 PROVIDER OR SUPPLIER JURIAN AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) in the sidewalk would not drain and water began to accumulate over the sidewalk near where 2 residents were seated. In interview with the Maintenance Director, at this time, he indicated the gutter needed an elbow as water was overshooting the roof and the drain was not working.	DENTIFICATION NUMBER: 155616 ROVIDER OR SUPPLIER RK NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) in the sidewalk would not drain and water began to accumulate over the sidewalk near where 2 residents were seated. In interview with the Maintenance Director, at this time, he indicated the gutter needed an elbow as water was overshooting the roof and the drain was not working. 3.1-19(f) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure physician progress notes were on the clinical record for 1 of 15 sampled residents progress notes reviewed. (Resident #20) Findings include: The clinical record for Resident #18 was reviewed on 6/13/11 at 2:25 p.m. The resident's diagnoses included, but were	ROVIDER OR SUPPLIER REWAITS AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) in the sidewalk would not drain and water began to accumulate over the sidewalk near where 2 residents were seated. 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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
AND PLAN	155616		A. BUIL		00	06/17/2011
100010			B. WIN		DDDEGG CITY CTATE ZID CODE	00/11/2011
NAME OF P	PROVIDER OR SUPPLIER			201 E E	ADDRESS, CITY, STATE, ZIP CODE	
	RK NURSING AND			1	LEM OT LBANY, IN47150	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG	chronic obstructives ident was read 1/14/11. When reviewing Notes, document record. In interviewing 6/14/11 at 8:35 awere no Progress the resident goes At 10:05 a.m., shown someone to the propress of the visit not work. On 6/17/11 at 10:05 a.m. at 10:05 a.m. and were no Progress Notes were on the progress of the visit not work. On 6/17/11 at 10:05 a.m. at 10:05 a	to the physician's office. The indicated she had sent hysician's office to get the as the fax machine did (14/11 at 11:55 a.m., the vere placed in the clinical to have the dates 17 a.m., the Director of the completed dates for in the record 1/15/09, 17/19/10, 7/28/10, and		TAG	CROSS-REFERENCED TO THE APPROPRIAT	DATE DATE
R0000						
	_	ate Residential Findings dance with 410 IAC	R0	0000	This plan of correction is to serve as Landmark Nursing Rehabilitation Center's cred	ı &

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616			(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/17/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
R0144	state of good repa shall provide reason residents. Sanitation and	Il be clean, orderly, and in a ir, both inside and out, and onable comfort for all afety Standards: 5.1-5(a) and interview, the facility of 10 residential dining room repair. In and interview, the facility of 10 residential dining room repair. In and interview, the facility of 10 residential dining room repair. In and interview, the facility of 10 residential dining room repair. In and interview, the facility of 10 residential dining room repair. In and interview, the facility of 10 residential dining room repair. In and interview, the facility of 10 residential dining room and the facility of 10 residential dining room and 10 chairs. In and interview, the facility of 10 residential dining room and 11 a.m., and the residential dining room and the residential dining room and 11 a.m., and the residential dining roo	R0144	allegation of compliance. Submission of this plan of correction does not const an admission by Landmar Nursing & Rehabilitation Center or its management company that the allegatic contained in the survey re is a true and accurate port of the provision of nursing and other services in this facility. Nor does this submission constitute an agreement or admission of survey allegations. I. 10 of 10 chairs have been repaired in Residential Area Review of other chairs in di room completed with no oth concerns identified. III. Housekeeping and Residential Staff were re-educated to vertically. Any identified condition will be submitted on a Build Services Request Form. IV Housekeeping Supervisor of designee will conduct audit twice/weekly of Residential Area to ensure chairs are in repair. The results of these will be reported to QA week four weeks, monthly for two months and quarterly therea V. Date of Completion: July 2011	itute k ions port trayal g care of the or s. Dining n good audits dy for of after.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616		A. BUILDING 00			COMPLETED		
		B. WING 06/17/2011					
NAME OF B	DOLUBER OR GURRI IER				ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF P	ROVIDER OR SUPPLIER			201 E E	ELM ST		
	RK NURSING AND				LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·	-	IAG	221 relative ()		DATE
R0214	(a) An evaluation of each resident shall admission and sha semiannually and change in the reside licensed nurse shaneeds of the reside Based on record facility failed to and evaluation was emiannually for reviewed in a sar Resident #7) Findings includes The clinical record #7 was reviewed The resident's diawere not limited stones, depression was admitted to the and discharged of Documentation was emi-annual eval November 2010.	of the individual needs of I be initiated prior to all be updated at least upon a known substantial dent's condition, or more nt's or facility's request. A all evaluate the nursing ent. review and interview the ensure the service plan was reviewed/revised 1 of 2 closed records nple of 7 (Residential red for residential resident on 6/14/11 at 2:15 p.m. agnoses included, but to history of kidney on and pain. The resident he facility on 5/28/10 n 3/31/11. vas lacking of a uation completed in	RO)214	I. Resident #7 no longer resin facility. II. All current Resident Service Plan and Assessments were reviewed/revised. III. Residential Care Staff we educated to completea a Resident Service Plan and Assessments upon admission and every six more thereafter or when a change condition occurs. IV. The Director of Nursing of designee will conduct audits the medical records to ensure Resident Service Plan and Assessments are compleupon admission, and every semonths thereafter or when a change in condition occurs. The results of these audits will be reported to QA weekly for forweeks, monthly for two monthand quarterly thereafter. V. Date of Completion: July 2011	re nths in r of e the eted iix The e	07/16/2011
		a.m., with the Medical e, she indicated she was			2011		
	_						
		ough the resident record					
	for the Service P	lan and a completed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616			(X2) MU	LTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING 00			06/17/2011	
1.000.10			B. WING		DDRESS, CITY, STATE, ZIP CODE	00/11/2	
NAME OF P	ROVIDER OR SUPPLIER			201 E E			
LANDMA	RK NURSING AND				_BANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		returned and indicated					
	the documentatio	on was not located.					
R0217	facility, using appromembers, shall ide services to be provided for a change (5) If administration provision of reside to be resident shall be a (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of and revised as approperation of the resident and factorized for a service provided for the service plan resident upon required. (4) No identification services provided is subsequent to the need for a change (5) If administration provision of reside both, is needed, a involved in identification services to be	ffered shall be reviewed propriate and discussed by acility as needs or desires facility or the resident may plan review. On service plan shall be play the resident, and a copy shall be given to the plant. In and documentation of its needed if evaluations initial evaluation indicate no in services. In of medications or the notial nursing services, or licensed nurse shall be pation and documentation of provided.	RO	217	I. Resident #6 no longer resid	des	07/16/2011
Based on record review and int facility failed to ensure the Service S			R02	217	I. Resident #6 no longer resident in Residential Area.II. All curron Resident Service Plan		07/16/2011
	and an Evaluation	n was completed on			and Assessments were reviewed/revised.III. Residential Care Staff were educated		
		or 7 sampled residents					
	reviewed for an e	evaluation and service					
					to completea a Resident Ser	vice	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE S	3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
155616		B. WING			06/17/2	011		
			B. WII		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER			201 E E				
LANDMA	RK NURSING AND	REHABILITATION			_BANY, IN47150			
					257 (1417, 11417, 100			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG		CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION DATE	
IAG		LSC IDENTIFYING INFORMATION)	+	IAG	,		DATE	
	plan. (Residentia	al Resident #6)			Plan and Assessments upon admission and every six mor			
					thereafter or when a change			
	Findings include				condition occurs.IV. The Dire			
					of Nursing or designee will	.0.01		
	The clinical reco	rd for Resident #6 was			conduct audits of the medica	ı		
		1/11 at 2:20 p.m. The			records to ensure the Reside	ent		
		ses included, but were			Service Plan			
	not limited to chr				and Assessments are comple			
					upon admission, and every s	ix		
	-	se and disorder of the			months thereafter or when a change in condition occurs.T	ho		
	prostate.				results of these audits will be			
	The resident was	admitted on 2/13/11 and			reported to QA weekly for fou			
	discharged to hos	spital on 5/10/11.			weeks, monthly for two mont			
					and quarterly thereafter. V. D			
	On 6/15/11 at 11	a.m., the Medical			of Completion: July 16, 2011			
		was going to look						
	_	ent record for the Service						
	•	leted evaluation. At						
		w with RN #1, she						
		he regular assessments						
	were done, but no	ot the Service Plan.						
R0273	(f) All food prepara	ation and serving areas	1					
	(excluding areas in	n residents ' units) are						
		ordance with state and local						
		e food handling standards,						
	including 410 IAC				I The O de an action and a succession		0=14.619.044	
	Food and Nutrition	onal Services: 5.5-1(f)	R0	273	 The 3 door refrigerator was cleaned. All undated food ite 		07/16/2011	
					were discarded. The food slid			
		n and interview the facility			was cleaned. Food temperat			
		ds were washed, equipment			are being recorded prior to e			
		peratures were recorded, food			meal service. The microwave			
		rded after three days for 1 of 2			oven was cleaned. The floor	mats		
		. This deficient practice had at 15 residential residents.			were removed and are no longer			
	me potential to affec	a 15 residentiai residents.			stored with food items. The			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155616	A. BUI	LDING	00	06/17/2	
	100010		B. WIN			00/17/2	011
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
				201 E E			
LANDIVIA	ARK NURSING AND	REHABILITATION		I NEW A	LBANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include:				gasket on the chest freezer v repaired. Plastic tubs and ute		
	On 06/13/11 hatsya	en the hours of 11:49 a.m.			were cleaned. The container		
		owing was observed:			were cleaned. Covers were	iido	
	12.20 p.m. uic 10110	wing was eeservea.			placed over the lights above	the	
	1. The 3 door refrig	gerator was soiled with a sticky			storage area for steam table		
	orange substance or	n the floor of the refrigerator.			and back door exit. Bowls ar	ıd	
					cups were cleaned. II. Daily Sanitation Checks were		
		t butter and jelly sandwiches on			completed to identify any furt	her	
		e. The dietary manager g should be dated and be			kitchen sanitation issues. No		
	discarded after three	=			were identified. III. Dietary Ai	de	
		vith tomato slices without a			#1 was reeducated on prope		
	date. C. Two lettuce salads without a date.				food handling and hand was		
					Dietary cleaning schedules a Daily Rounds form were draf		
		of fruit cocktail without a date.			and approved by QA Commi		
		iner of fruit cocktail dated			All dietary employees will be		
	5/25/11.	6 44 1 34			reeducated on proper food		
	date.	of cottage cheese without a			storage and labeling, proper		
		ll dishes of applesauce without			cleaning techniques, proper		
	a date.	in dishes of appresauce without			handling, hand washing and time temperature recording.		
	I. A container of	of Mandarin oranges lacked a			The Dietary Supervisor or	ıv.	
	date.				designee will conduct daily a	udits	
					of food storage, food labeling] ,	
		was soiled with dried food			food temperature logs and		
	used the evening be	manager indicated it was last			sanitation of dietary departm		
	used the evening be	note.			The results of these audits w reported to QA weekly for for		
	4. Food temperatur	res for the breakfast meal were			weeks, monthly for two mont		
		50 a.m. In interview with the			and quarterly thereafter. V. D		
	cook, at this time, si	he indicated she took them but			of Completion: July 16, 2011		
	failed to record ther	n.					
		9.1.3.4					
		oven was soiled on the inner					
	surface with a stick	y orown substance.					
	6. Two rubber floor	r mats were rolled up on a shelf					
		iter. The dietary manager					
		were placed on the shelf when					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155616		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 06/17/2	LETED	
	PROVIDER OR SUPPLIER		STREET A 201 E E	address, city, state, zip c ELM ST LBANY, IN47150	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		ed last evening. Packages of c bags were also stored on the				
		e chest freezer was loose sches in one area and 2 inches				
	8. Plastic tubs with utensils stored in them were soiled with food crumbs/debris on the inner surfaces.					
		ontainers for sugar and food and with a sticky substance.				
	10. Dietary aide #1, was observed to drop margarine pats on the floor and lifted the lid of the trash can with bare hand and disposed of the margarine. She continued to prepare the trays for lunch without washing her hands.11. The ceiling lights in the storage area for steam table pans and the back door exit lacked a cover.					
		en bowls stored as clean were oris on the inner surfaces.				
	_	cups stored as clean were oris on the inner surfaces.				